Indiana Veterans' Home

APPLICATION FOR ADMISSION

of

_____
Veteran

Veteran _____

From _____ County

Superintendent's Recommendation:

_____

DISPOSITION OF APPLICATION

The within application is _____

this _____ day of _____, 20__,

and said application will _____ be

admitted to the Indiana Veteran's Home.

_____
Signature of Superintendent

FAILURE TO ANSWER ALL QUESTIONS MAY DELAY THE ADMISSION OF THE APPLICANT

Application must be acted upon favorably by the State Health Commissioner, Indiana State Board of Health, and applicants notified of such action before they can be admitted.

The Commissioner's action is governed by certain legal requirements for admission and availability of care services and facilities.

Date approved *(month, day, year)*	Date disapproved *(month, day, year)*
Signature	Signature

FEDERAL REGULATION Public Law 22.

This State Agency is requesting your Social Security number only to expedite the processing of this form. You are not required to provide this information and cannot be penalized for declining to provide it.

The information contained on this form is **CONFIDENTIAL.**

APPLICATION OF VETERAN FOR ADMISSION TO INDIANA VETERANS' HOME

State Form 37561 (R5 / 9-04) Form A No.1

INSTRUCTIONS:

- *Complete the Application for Admission as thoroughly as possible. Every blank must be filled in. If the questions does not apply, write "NA".*
- *A copy of your DD-214, or a copy of your discharge indicating both your date of induction and date of discharge. We cannot process your application until we receive these documents.*
- *Any monthly income reported on the Application for Admission must be verified by sending with the application, a copy of the monthly check or, in cases of direct deposit, a copy of the deposit slip.*
- *Any bank accounts reported on the Application for Admission must be verified by sending with the form, a copy of the most recent bank statement.*
- *All married applicants must provide a copy of the marriage certificate as well as verifying joint resources and income.*
- *All applicants, the applicant's Power of Attorney or the applicant's guardian must send with the form, a statement from the county of residence indicating whether the applicant has or has not owned any property in the county of residence for the past five years. A copy of the Guardianship or Power of Attorney must be included with the application.*
- *Failure to send verifications requested will delay the request for admission to the Indiana Veterans' Home. The Admissions Department will assist you, if needed. However, the responsibility for providing the information rests with you.*

Name (first, middle, last)	Age	Race

Date of birth *(month, day, year)*	Place of birth	Religion

Present address in full *(number and street or Rural Route, city, state and ZIP code)*	Telephone number (with area code) ( )
	Are you? *(check applicable)* ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Give record of all marriages below:

NAME OF SPOUSE	DATE AND PLACE OF MARRIAGE	DATE AND PLACE OF DEATH

Give your military service below:

ENLISTMENT	BRANCH OF SERVICE	DATE AND PLACE OF ENLISTMENT	DATE AND PLACE OF DISCHARGE

Where have you resided for the past three (3) years? (state below in detail)

STREET ADDRESS	CITY	STATE	FROM	TO

MEDICARE NUMBER	What is, or was your occupation?	
What pension do you receive? *(VA, RR, etc.)*	Amount $	Certificate number

Do you receive Social Security? ☐ Yes ☐ No	If Yes, amount? $	Social Security number
Do you have any other income? ☐ Yes ☐ No	If Yes, amount? $	From what source?
Have you any money in a bank or otherwise? ☐ Yes ☐ No	If Yes, amount? $	Have you owned any property within the last three years? *(attach property description)* ☐ Yes ☐ No
Have you any stocks or bonds or Certificates of Deposit? ☐ Yes ☐ No	If Yes, current value? $	If Yes to above, what is assessed value? $
Do you manage your personal affairs? ☐ Yes ☐ No	Explain	
Do you have a will? ☐ Yes ☐ No	Who are your beneficiaries?	

Name the person with whom you have the closest contact	In case of death, to whom are your personal belongings to go?

Give name, address and telephone number of children or nearest relative below:

NAME	ADDRESS	RELATIONSHIP	TELEPHONE HUMBER

Do you have a prepaid funeral? ☐ Yes ☐ No	If Yes, with whom?		
Do you have life insurance? ☐ Yes ☐ No	If Yes, with whom?	Face value	Policy(s) number(s)

Are you currently a resident of a residential or care facility? ☐ Yes ☐ No	Do you agree to abide by all the laws and regulations governing the Home? ☐ Yes ☐ No

Do you, in consideration of being admitted and maintained in the Indiana Veteran's Home, understand that you or your estate are obligated to pay full cost of care and maintenance? *(Depending on the amount of your current assets and income from any source this rate may be reduced.)* ☐ Yes ☐ No

I have read, or have heard read, the foregoing questions and my answers thereto are true and correct, and they are voluntarily made by me for the purpose of gaining admittance to and receiving the benefits of the Indiana Veterans' Home.

Signature of applicant — Date signed *(month, day, year)*

NOTARY CERTIFICATE

STATE OF _____

COUNTY OF _____ } SS:

Subscribed and sworn to before me, this _____ day of _____, 20 _____.

Signature of Signature of Notary Public	County of residence
Printed or typed name of Notary Public	Date commission expires

RESIDENCE CERTIFICATE

STATE OF _____

COUNTY OF _____ } SS:

I, the undersigned Township, City or County Official, do hereby state on oath, that the person making the attached application for membership in the Indiana Veteran's Home has been a resident of said County prior to making of the application. I know that the applicant is at the time of making application and has for three (3) years prior thereto, been a bonafide resident of the State of Indiana.

Printed or typed name of official	Official title of official
Signature of official	
Address of official	

Dated this _____ day of _____, 20 _____.

THE ABOVE CERTIFICATION SHOULD BE MADE BY AN ELECTED TOWNSHIP, CITY OR COUNTY OFFICIAL

MILITARY SERVICE INFORMATION

Since the Indiana Veterans' Home serves only the war time veteran, the following information is requested.

Do you have a service connected disability? ☐ Yes ☐ No	If Yes, do you receive compensation for this disability? ☐ Yes ☐ No	If Yes, what is the amount of your compensation? $
Are you a former prisoner of war? ☐ Yes ☐ No	Were you awarded the Purple Heart? ☐ Yes ☐ No	

Do you belong to one or more of the following Veterans' Service organizations?

American Legion ☐ Yes ☐ No — Disabled American Veterans ☐ Yes ☐ No

Veterans of Foreign Wars ☐ Yes ☐ No — Other (give name of organization) _____

DIRECTIONS FOR APPLICATION PROCESS

We welcome your interest in applying for residency at the Indiana Veterans' Home. The following information will be needed to complete your application.

1. Completed application form.

2. A copy of your Military Discharge (DD214) is needed. This **must** show your actual service dates, entry and discharge into the service.

3. A letter from the County Auditor's Office from the county you reside in stating **whether or not** you have owned property within the last three years. If you own property your property tax statement can also be used.

4. Copies of Power of Attorney or Guardianship papers, if applicable.

5. Copy of your marriage certificate if you are currently married OR the widow of a veteran.

6. A completed History & Physical form which also includes the following:
A **Chest X-ray** (radiologist's report only) not over 6 months old and a TB test not over 3 months old and a **listing of your current medications and the dosage.**

7. A properly **notarized signature** is needed on the application.

8. The Residency Statement must be complete. Someone not related can verify you have lived in Indiana for the last three (3) years. This does not have to be notarized.

9. If you are seeking residency but your spouse will be staying in the community, he/she will need to fill out a "Maintenance Worksheet for Dependents" so that all financial needs can be determined. Please request this form from the Admissions Department.

10. Copy of social security card.

11. Copy of your medical insurance card(s), **front and back**. (Medicare, Etc.)

12. Copy of Life and medical insurance policy and premium payment book.

13. Financial information as applicable per the enclosure in the application packet

14. If you are requesting to bring a car to the facility, we will need a copy of your vehicle registration, car insurance and driver's license. These must be current.

15. Due to the increase in Identity Theft, you may **voluntarily** keep a copy of your credit cards (front & back) locked in our Trust Dept.

16. If you are admitting from home, a pre-admission screening from the Area Agency on Aging, in your area.

If you have any questions in regard to the application process, you can contact the Admission/Marketing Director 765-497-8072 or the Assistant at 765-497-8635.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of my protected health information as described below. I understand signing this authorization is voluntary and I do not need to sign this form to assure treatment, payment or eligibility of benefits. I understand that the information disclosed may be subject to re-disclosure by the recipient and the privacy of the information may no longer be protected by the law.

The specific organization that is authorized to disclose my protected health information is:

_____

(Name and Address of Facility/individual to Release the Protected Health Information)

The specific organization or individual to which the information is to be released:

_____

(Name and Address of Facility/individual to Receive the Protected Health Information)

The specific protected health information that is authorized to be disclosed is:

- ☐ Physician order
- ☐ Physician progress notes
- ☐ History and physical
- ☐ Immunization record & TB Screening
- ☐ Nurses' notes
- ☐ Discipline specific progress notes. Specify: _____
- ☐ Medication record
- ☐ Treatment record
- ☐ Laboratory results
- ☐ X-ray and imaging reports
- ☐ Consultation reports

Other: _____

_____

The purpose of the disclosure of my protected health information is:

_____

I understand this authorization is automatically void on the following date, event or condition _____, but in any case, is only in effect sixty (60) days from the date of signature below under Indiana Law.

I understand that I may revoke this authorization at any time by notifying the organization in writing, but if I do it won't have any effect on any actions taken before the revocation was received.

By signing this authorization, I acknowledge that I have read and understand this authorization. I understand that my protected health information will be disclosed in accordance with this authorization.

_____ _____

Signature of resident or authorized representative Date

_____ _____

Printed name of resident or authorized representative

_____ _____

Description of authority, if signed by representative Address of resident or authorized representative

AUTHORIZATION TO RELEASE FINANCIAL INFORMATION AND RELEASE OF LIABILITY

I hereby authorize _____ and its employees, agents and representatives to release my personal and financial information to the **Indiana Veterans' Home, 3851 North River Road, West Lafayette, IN 47906.**

I agree that I will release and hold harmless from any and all responsibility and liability the above referenced organization and its employees, agents and representatives for disclosure of any such information. I further agree not to make a claim against or sue said organization and its employees, agents and representatives for the release and disclosure of such information.

_____ _____

Signature Date

_____

Print Name

_____

Social Security Number

_____

Date of Birth

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
Indiana Veterans' Home	3851 North River Road, West Lafayette, IN 47906

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

____ Social Security Number
____ Identifying information (includes date and place of birth, parents' names)
____ Monthly Social Security benefit amount
____ Monthly Supplemental Security Income payment amount
____ Information about benefits/payments I received from _____ to _____
____ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
____ Medical records
____ Record(s) from my file (specify) _____
____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)
Date: _____ Relationship: _____

Form Approved
OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- **nonmedical** records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

How to Complete This Form

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the **nonmedical** information applies, or
  the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PRIVACY ACT NOTICE: The Privacy Act Notice requires us to notify you that we are authorized to collect this information by section 3 of the Privacy Act. You do not have to provide the information requested. However, we cannot release information or records about you to another person or organization without your consent for release of information. Your records are confidential. We will release only records that you authorize, and only to persons or organizations who you authorize to receive that information.

PAPERWORK REDUCTION ACT STATEMENT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 212345-6401. Send only comments relating to our time estimate to this address, not the completed form.*

STATE OF INDIANA

MITCHELL E. DANIELS, JR., Governor

INDIANA VETERANS' HOME
3851 N. River Road
West Lafayette, IN 47906
Telephone: (765) 463-1502

Paperwork which the Business Office **MUST** have upon receipt of an application for a new resident:

Financial Statements for the resident, their spouse (if applicable), and any dependents (if applicable):

- ***These statements must be current.*** Current being defined as within 37 days of the admission date for monthly statements; within 104 days of the admission date for quarterly statements; and within 13 months of the admission date for annual statements.

- Financial Statements include, but are not limited to the following:
  - Bank Statements
  - Checks and check stubs for all monthly income received via a physical check.
  - EFT receipts for all monthly income received via direct deposit.
  - Account statements for any stocks, bonds, mutual funds, IRAs, CDs, Keogh Plans, etc
  - Property tax or other assessment showing the estimated value of any real property.
  - Rental agreements for any rental income.
  - Life insurance information: company contact information, policy #'s, cash surrender value, face amount, amount of premiums (if not already paid off), and beneficiaries.
  - Funeral Trust statements or prepaid funeral contracts.

- If the resident has dependents requesting some of their monthly income, they must fill out a dependent worksheet showing **MONTHLY** estimated expenditures. They must be able to substantiate and justify the expenditures as well.

- Additional financial items that would be *extremely helpful* to have:
  - 1099 and/or W-2 forms for the previous calendar year.
  - Award letters for Social Security, VA Benefits, Railroad Retirement, SSI, Civil Service Retirement, Military Retirement, etc. (These are normally sent out annually.)

Medicaid Information: If a Resident is receiving Medicaid assistance due to their need for long-term nursing care, the IVH Business Office must be notified and provided the contact information of the previous facility and the Resident's Medicaid liability prior to them being admitted.

All items **MUST BE LEGIBLE.**

In addition, if a resident does not, or is unable to manage their own finances, the responsible party must be available upon admission.

09/2007 BB/BUS

Authorization to Release Information

I, (Please Print Clearly)_____, hereby authorize any person or entity, public or private, having any information concerning my background, including but not limited to criminal law violations to release such information to a state agency. This information is to be used for possible admission to the Indiana Veterans' Home.

I understand that if the Indiana Veterans' Home requests a national check of the Criminal History Records Information Database, I have the following rights:

- To obtain a copy of any background check report; and
- To challenge the accuracy and completeness of any information contained in any such report and obtain prompt determination as to the validity of such challenge before a final determination is made by the Indiana Veterans' Home.

I further authorize, intend and understand that this release of information shall continue and remain in full force and effect until such time as I am admitted to the Indiana Veterans' Home or for thirty (30) days, whichever is greater.

_____ _____ Male/Female (Circle One)
Signature Date

_____ _____
Street Address Date of Birth

_____ _____
City, State, Zip Code Telephone Number

_____ _____
Other Name(s) Used Social Security Number

_____

Other information the resident and/or responsible party needs to supply:

Medical Expense Information:

- Resident and/or responsible party should be able to provide a reasonable estimate of the total unreimbursed medical expenses paid during the **previous calendar year** for the resident and their dependents.

- If the resident's dependents **currently** have any unreimbursed, recurring medical expenses, paperwork should be provided to substantiate them. Unreimbursed, recurring medical expenses could include the following: health insurance premiums, medications taken on a regular basis (both prescription and over-the-counter), monthly assisted living or nursing home expenses, etc. Please fill in the below table, the first three entries are provided as an example. If additional entries are needed, attach a separate sheet.

	DOLLAR AMOUNT	PAYMENT DATE (i.e. monthly, quarterly, annual)	PURPOSE (Doctor's fees, hospital charges, nursing care, etc)	PAID TO (Name of doctor, hospital, pharmacy, nursing home, attorney, etc)	NAME OF PERSON FOR WHOM EXPENSES WERE PAID
EXAMPLE	$ 93.50	Monthly	Medicare Deduction	Social Security	John Doe
EXAMPLE	$ 250.00	Monthly	Health Insurance	Blue Cross/Blue Shield	Jane Doe
EXAMPLE	$ 3650.00	Monthly	Assisted Living	Meadows Assisted Living	Jane Doe

Personal Data/Legal Information for Resident's with Dependents:

Dependent Name	Social Security Number	Date of Birth

- Previous marriage information, *this applies only to residents that are married or are being admitted as a surviving spouse*. The following information must be provided for **BOTH** the resident and their spouse for **ALL** prior marriages:
    - **Who they married**.
    - **When they married** – *approximate dates are OK*.
    - Where they married.
    - **When the marriage ended** – *approximate dates are OK*.
    - Where the marriage ended,
    - **How the marriage ended (death or divorce)**.

Date of Marriage (mo/day/yr)	Place of Marriage (city/state or country)	Persons Married	Date Marriage Ended (mo/day/yr)	Why did the marriage end? (death or divorce)	Place Marriage Ended (city/state or country)

Additional Notes: